

CERTIFICATE OF MEDICAL NECESSITY		DMERC 07.02A
SEAT LIFT MECHANISM		
SECTION A	CERTIFICATION TYPE/DATE: INITIAL <u> / </u> REVISED <u> / </u>	
PATENT NAME, ADDRESS, TELEPHONE AND HIC NUMBER		SUPPLIER NAME, ADDRESS, TELEPHONE AND NSC NUMBER
<u> </u> HICN		<u> </u> NSC#
PLACE OF SERVICE NAME AND ADDRESS OF FACULTY IF APPLICABLE (SEE REVERSE)	HCPCS CODE <u> </u> <u> </u> <u> </u>	PT DOB <u> / </u> ; SEX(M/F); HT <u> </u> (IN.); WT <u> </u> (LBS.) PHYSICIAN NAME, ADDRESS (PRINTED OR TYPED) PHYSICIAN'S UPIN: PHYSICIAN'S TELEPHONE #: <u> </u>
SECTION B INFORMATION IN THIS SECTION MAY NOT BE COMPLETED BY THE SUPPLIER OF THE ITEMS/SUPPLIES.		
EST. LENGTH OF NEED (# OF MONTHS): <u> </u> 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): <u> </u> <u> </u> <u> </u>
ANSWERS	ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (CIRCLE Y FOR YES, N FOR NO, OR D FOR DOES NOT APPLY)	
Y N D	1. DOES THE PATIENT HAVE SEVERE ARTHRITIS OF THE HIP OR KNEE?	
Y N D	2. DOES THE PATIENT HAVE A SEVERE NEUROMUSCULAR DISEASE?	
Y N D	3. IS THE PATIENT COMPLETELY INCAPABLE OF STANDING UP FROM A REGULAR ARMCHAIR OR ANY CHAIR IN HIS/HER HOME?	
Y N D	4. ONCE STANDING, DOES THE PATIENT HAVE THE ABILITY TO AMBULATE?	
Y N D	5. HAVE ALL APPROPRIATE THERAPEUTIC MODALITIES TO ENABLE THE PATIENT TO TRANSFER FROM A CHAIR TO A STANDING POSITION (E.G. MEDICATION, PHYSICAL THERAPY) BEEN TRIED AND FAILED? IF YES, THIS IS DOCUMENTED IN THE PATIENTS MEDICAL RECORDS.	
NAME OF PERSON ANSWERING SECTION B QUESTIONS. IF OTHER THAN PHYSICIAN (PLEASE PRINT): NAME: <u> </u> TITLE: <u> </u> EMPLOYER: <u> </u>		
SECTION C NARRATIVE DESCRIPTION OF EQUIPMENT AND COST		
(1) NARRATIVE DESCRIPTION OF ALL ITEMS, ACCESSORIES AND OPTIONS ORDERED; (2) SUPPLIER'S CHARGE; AND (3) MEDICARE FEE SCHEDULE ALLOWANCE FOR EACH ITEM, ACCESSORY, AND OPTION. (SEE INSTRUCTIONS ON BACK)		
SECTION D PHYSICIAN ATTESTATION AND SIGNATURE/DATE		
I CERTIFY THAT I AM THE PHYSICIAN IDENTIFIED IN SECTION A OF THIS FORM. I HAVE RECEIVED SECTIONS A, B AND C OF THE CERTIFICATE OF MEDICAL NECESSITY (INCLUDING CHARGES FOR ITEMS ORDERED). ANY STATEMENT ON MY LETTERHEAD ATTACHED HERETO, HAS BEEN REVIEWED AND SIGNED BY ME. I CERTIFY THAT THE MEDICAL NECESSITY INFORMATION IN SECTION B IS TRUE, ACCURATE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT ANY FALSIFICATION, ERASURE, OR CONCEALMENT OF MATERIAL FACT IN THAT SECTION MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.		
PHYSICIANS SIGNATURE		DATE <u> / </u> <u> </u> (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

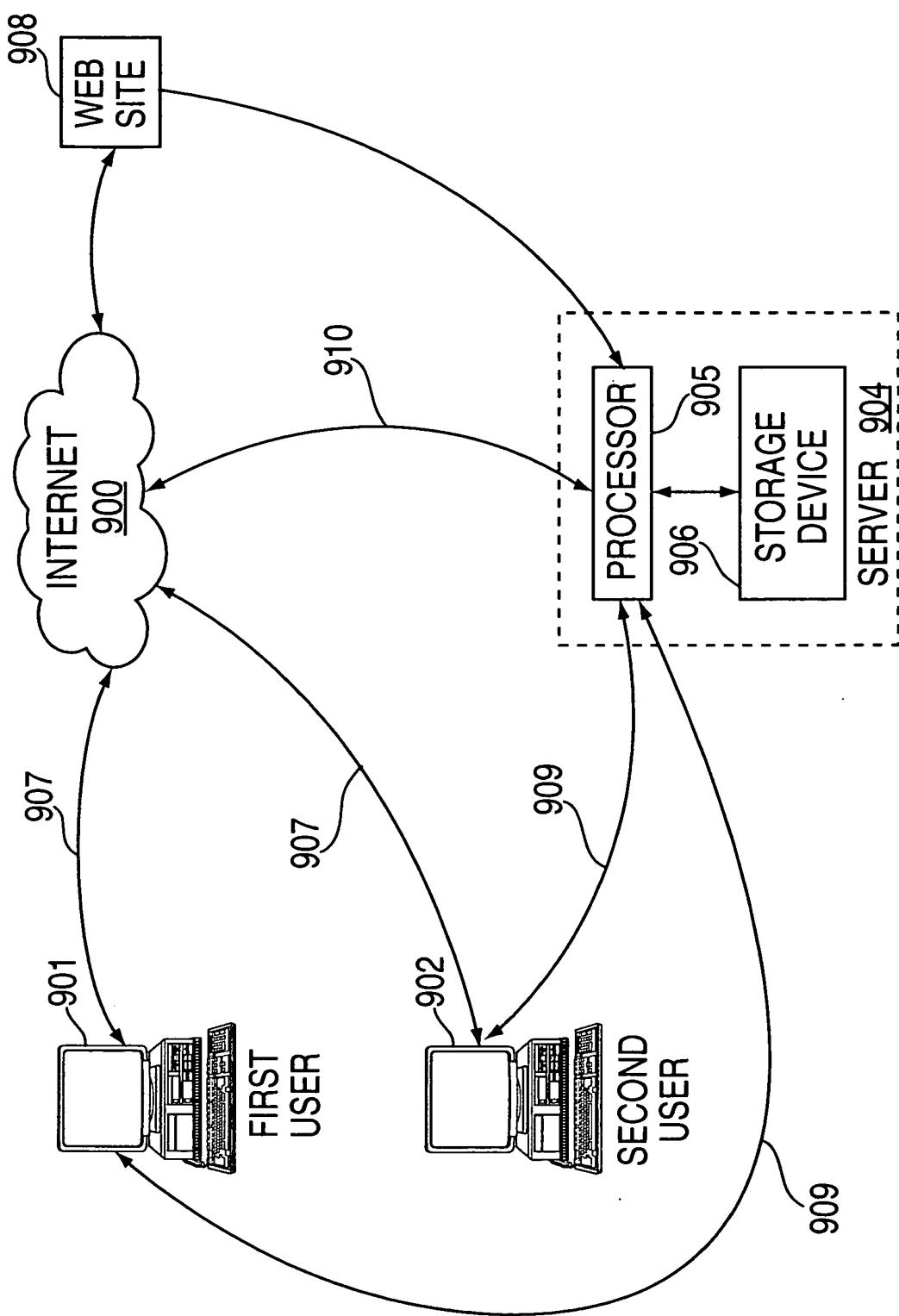
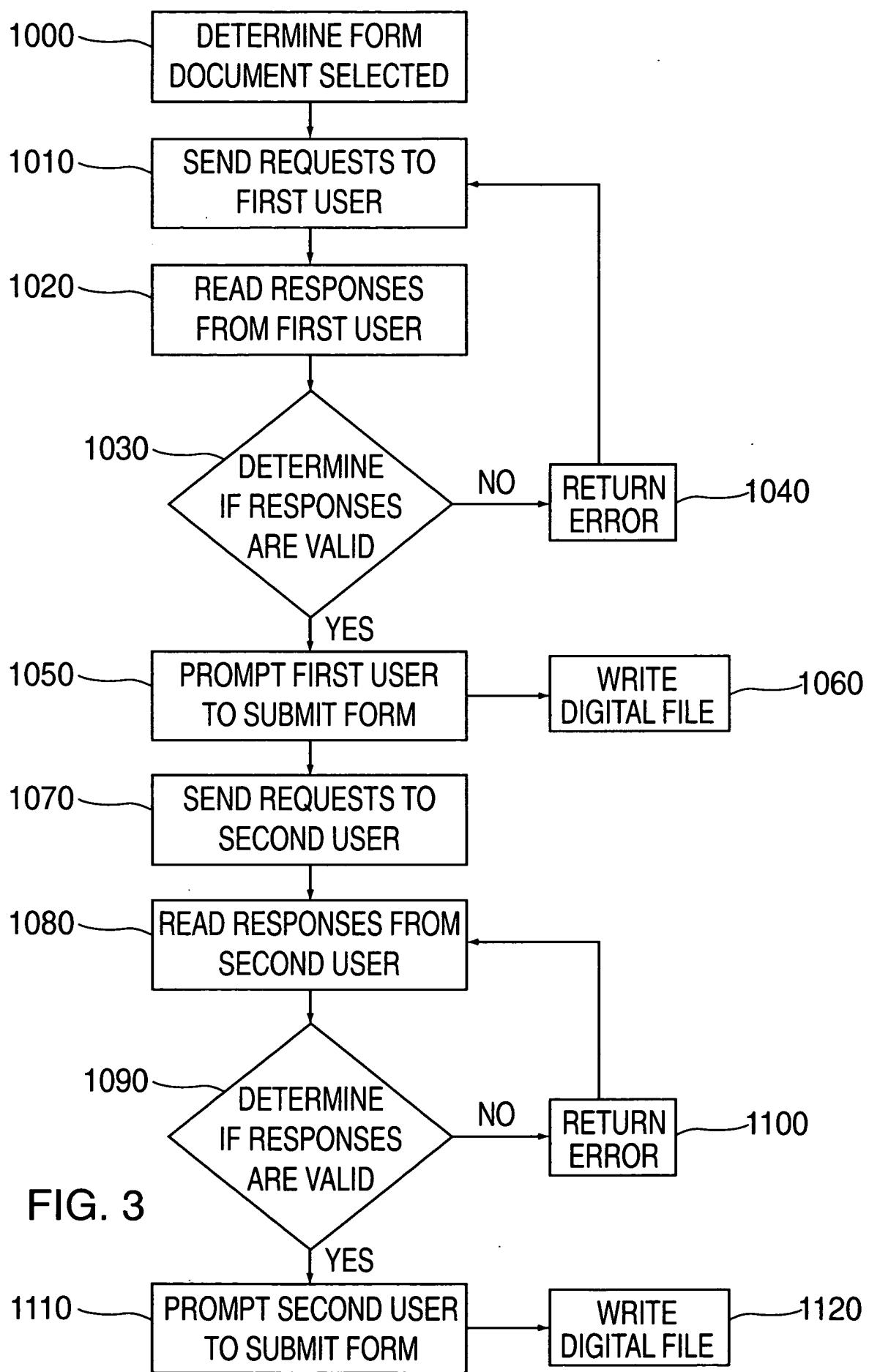


FIG. 2



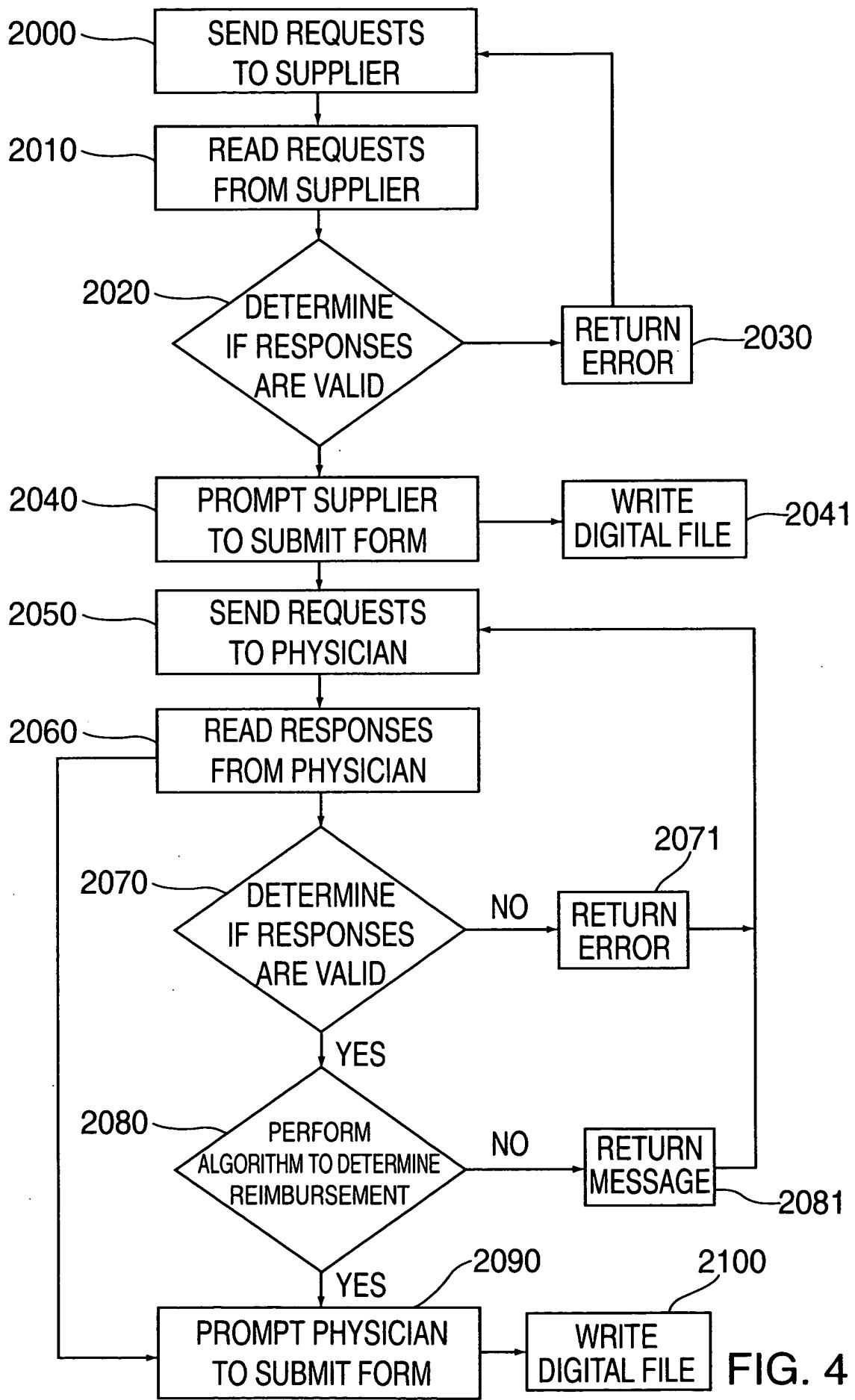
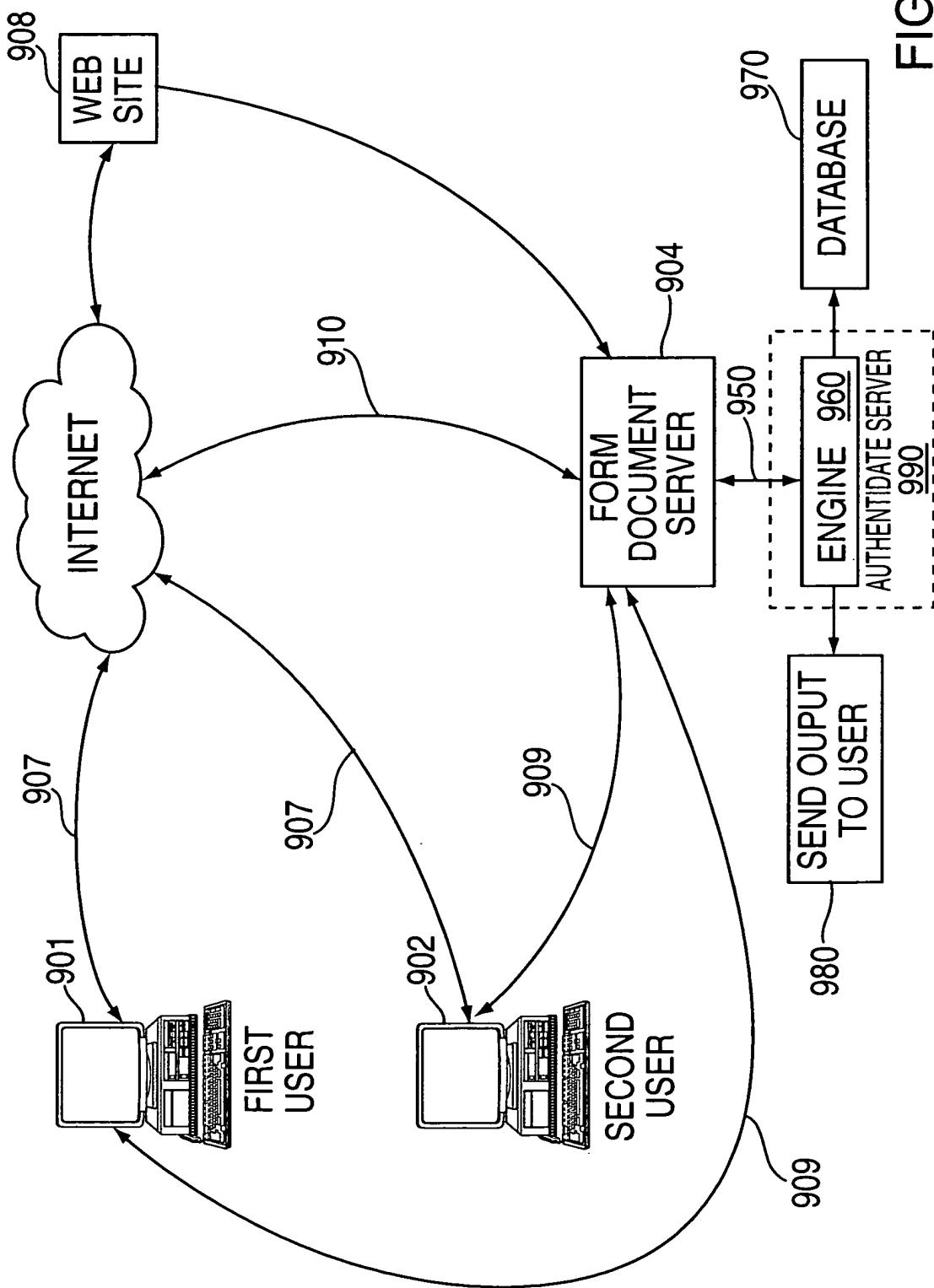


FIG. 4



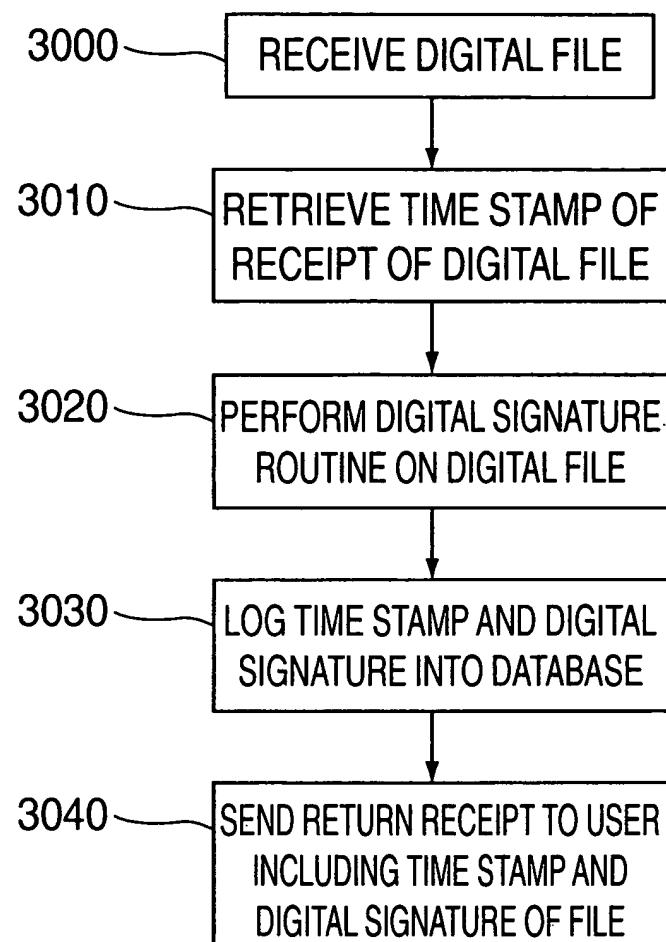


FIG. 6

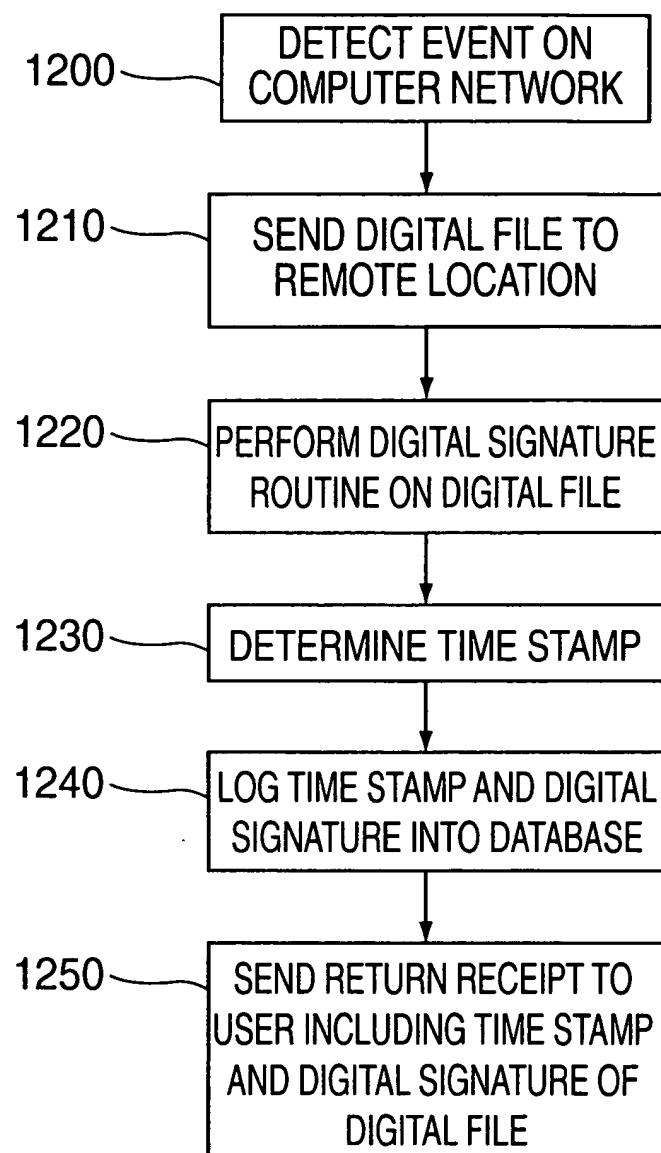


FIG. 7